Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

G PETER FOOX MD
1405 S FLEISHEL AVE SUITE 330
TYLER TX 75701

Carrier's Austin Representative Box
Box Number 54

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Date Received
August 8, 2011

MFDR Tracking Number
M4-11-4553-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "FEE GUIDES NEED TO BE RESPECTED BY TX MUTUAL & PAY ACCORDINGLY."

Amount in Dispute: $123.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.204 at (j)(3)(B)(i) states, 'If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has…previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection…' Review of Texas Mutual's claim does reveal the requestor has treated the claimant. Subsection (3)(A) indicates with respect to billing and reimbursement of an MMI evaluation code 99455 is to be used with the appropriate modifier. Specifically, it states 'Reimbursement shall be the applicable established patient office visit level associated with the examination…Modifiers'V1', 'V2', 'V3', 'V4', or 'V5' shall be added to the CPT code to correspond with the last digit of the applicable office visit.' Texas Mutual understands this to mean that code 99455-V5, as the requestor billed, is paid with the MAR for code 99215, which is $214.64. The requestor used the DRE methodology to determine impairment. The same Rule indicates the DRE method is paid at $150.00. Therefore, $214.64 + $150.00 = $364.80. For his part the request has not explained how 99455 = $350.00 and V5 = $144.00. For these reasons no additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011	99455-V5-WP	$123.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 12, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Issues

1. Has the MMI/IR examination been reimbursed appropriately per 28 Texas Administrative Code §§134.204 and 134.203?
2. Is the requestor entitled to additional reimbursement for the disputed service under Texas Administrative Code §§134.204 and 134.203?

Findings

1. 28 Texas Administrative Code §134.204(j)(3)(A)(i)(ii) and (B)(i):

   (j) Maximum Medical Improvement and/or Impairment Rating (MMI\IR) examinations shall be billed and reimbursed as follows:

   (3) The following applies for billing and reimbursement of an MMI evaluation.

   (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

   (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

   (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

   (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

   (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection.

   28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I):

   (4) The following applies for billing and reimbursement of an IR evaluation:

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (ii) The MAR for musculoskeletal body areas shall be as follows:

   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   The services rendered represent evaluation and management office visit level, not the billed code for DWC specific services.

   The requestor billed 99455-V5-WP. Per 28 Texas Administrative Code §134.203(c) reimbursement for the evaluation and management office visit level, CPT Code 99215 is as follows: $54.54 WC CF/33.9764 Medicare CF x $133.81 = $214.80. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I) the Maximum Allowable Reimbursement (MAR) for the Impairment Rating using the Diagnosis Related Estimates (DRE) method is $150.00. The total MAR is $214.80 + $150.00 = $364.80.

2. The respondent has previously reimbursed the amount of $364.80 for the disputed CPT code 99455-V5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 7, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.